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PRESS RELEASE
HEALTH AND HUMAN SERVICES AGENCY

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GOV. SCHWARZENEGGER DIRECTS THE DEPARTMENT OF HEALTH SERVICES TO EXPAND EFFORTS TO PROTECT THE FISCAL INTEGRITY OF MEDI-CAL

Nation-Leading Report Better Identifies Errors and Potential Fraud Within Program

SACRAMENTO – Gov. Schwarzenegger today directed the Department of Health Services (DHS) to expand ongoing efforts to protect the fiscal integrity of Medi-Cal, based upon findings of a new study on payment errors within the program.

The second annual Medi-Cal Payment Error Study (MPES) was conducted by DHS and is the nation's most comprehensive study of payment error in a state Medicaid program.

"This study, which is the only one of its kind in the nation, is a very valuable tool that helps guide our anti-fraud efforts," said Kimberly Belshé, secretary of the California Health and Human Services Agency. "If you want to eliminate fraud and abuse in taxpayer-funded health care programs, you must first identify where these problems exist, measure them and then take action."

This year's study used a more controlled claims review process including an improved sampling to focus more precisely on high risk provider categories, a more standardized review process that included comprehensive reviewer training and additional reviews of beneficiary eligibility.

"This year's Medi-Cal Payment Error Study better identifies errors and potentially fraudulent claims within the Medi-Cal program," said Belshé.

The Governor directed DHS to immediately implement the following program improvements:

- Increase the number of claims receiving secondary extensive review to detect fraud earlier. This activity is now underway.
- Conduct onsite reviews of approximately 2,000 pharmacies to verify compliance with regulations, identify overpayments, uncover potential fraud and abuse and deter further abuse.
- Use new, customized anti-fraud technology to better identify potential fraud schemes.
- Work with the Legislature to reform Adult Day Health Care centers by revising the payment methodology and implementing more intensive monitoring.
- Develop a joint plan of action with regulatory boards and provider associations to address provider claim errors.

In addition, the Governor called on DHS to arrange for an independent, top-to-bottom evaluation of DHS' anti-fraud program and identify any gaps in its efforts to protect the fiscal integrity of Medi-Cal. This assessment is intended to ensure that DHS is taking every appropriate action to prevent Medi-Cal fraud and payment error. The results of this evaluation are due no later than July 2007.

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"Governor Schwarzenegger has taken an aggressive approach to guarding Medi-Cal from those who would abuse the program," said Belshé. "If we did not identify where Medi-Cal is at greatest risk for paying claims with provider errors, we would not have a clear roadmap for stamping out errors and fraud in Medi-Cal."

MPES is a unique study because every provider claim for payment used in the sample is thoroughly investigated back to the claim's origins. It is also the only study conducted by any state or federal agency that includes an estimate of potentially fraudulent claims.

MPES 2005 found that 3.23 percent of payments to providers in 2004 were for claims that were potentially fraudulent. However, to determine exactly how many of the claims were indeed fraudulent would require a complete criminal investigation. Overall, 8.4 percent of the amount paid to Medi-Cal providers in 2004 were for provider claims that were in error or potentially fraudulent. The type of error that was the most costly in general was that the provider's claim was for services that were unnecessary. These are cases where a provider made a determination of medical necessity and upon review of the case DHS concluded the service was not medically necessary. In addition, pharmacy claim errors were responsible for almost half of the amount paid for erroneous or potentially fraudulent claims. Most pharmacy claim errors were a result of inadequate documentation. In contrast, no errors were found among claims by institutional providers, such as hospitals and nursing homes.

"These provider errors are unacceptable," said Belshé.

MPES 2005 focused on the Medi-Cal fee-for-service medical and dental programs because they directly pay the largest number of individual providers and have the greatest risk for fraud. The report also found that:

- 91.6 percent of reimbursements paid in the fee-for-service and medical and dental programs were for claims that were billed appropriately, paid accurately, for medically necessary services and delivered by an eligible Medi-Cal provider to eligible Medi-Cal beneficiaries.
- 45 percent of the amount paid to claims with errors was paid to claims for services that were unnecessary. Overall, this type of error was the most costly.
- 37 percent of the amount paid to claims with errors was paid to claims with insufficient documentation.
- Among non-institutional providers, the majority of errors were found in the pharmacy and physician categories.
- No errors were found in the state's pricing or claims processing system.
- Adult Day Health Care centers had the highest percentage of claims that were completely in error and the greatest number in which there was no medical necessity for the services provided.

To view the full report, log on to www.dhs.ca.gov and click on the link "Get the latest on efforts to combat Medi-Cal fraud. Read More!"

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